

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-012026

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

146

Primary Registration District No.

3026

Registrar's No.

161

STATE FILE NUMBER

FILED APR 9 1963

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		c. CITY OR TOWN Independence	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 417 East Short		d. STREET ADDRESS 417 East Short	
3. NAME OF DECEASED (Type or print) Minnie May Couser		4. DATE OF DEATH Month April Day 1 Year 1963	
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11a. FATHER'S NAME Charles Morgan		11b. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ruth E. Campbell-417 E. Short, Indep. Mo.		14. NAME OF HUSBAND OR WIFE William John Couser	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Arteriosclerotic Hypertension DUE TO (c) Diabetes		INTERVAL BETWEEN ONSET AND DEATH 2 days 13 yrs. 2 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. Month, Day, Year		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY	
20g. STATE			
21. I attended the deceased from Jan 1950 to 1 April 63 and last saw him alive on 31 March 63 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE E. Anderson (Degree or title)		22b. ADDRESS Independence	
22c. DATE SIGNED 4-2-63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 4, 1963	
23c. NAME OF CEMETERY OR CREMATORY Mound Grove Cem.		23d. LOCATION (City, town, or county) (State) Independence, Missouri	
24. FUNERAL DIRECTOR Geo. C. Carson & Son-Indep. Missouri		25. DATE RECD. BY LOCAL REG. 4-3-63	
26. REGISTRAR'S SIGNATURE Alba L. Craig			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 12 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

J. T. Cramell

Licensed Embalmer No. 4904

P. O. Address H. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

4-2-63

4-2-63